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In the

Supreme Court of the United States.

October Term, 1935.

No. 602

New York Life Insurance Company,

Petitioner,

v.

Demetrios P. Viglas,

Respondent.

Petition for a Writ of Certiorari to the Circuit Court of Appeals for the First Circuit

and

Brief in Support Thereof.

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In the

Supreme Court of the United States.

OCTOBER TERM, 1935.

No.

NEW YORK LIFE INSURANCE COMPANY,

PETITIONER,

v.

DEMETRIOS P. VIGLAS,

RESPONDENT.

PETITION FOR A WRIT OF CERTIORARI TO THE CIRCUIT COURT OF APPEALS FOR THE FIRST CIRCUIT.

To the Honourable the Justices of the Supreme Court of the United States:

The undersigned, on behalf of New York Life Insurance Company, the above-named petitioner, pray that a writ of certiorari may issue to review the judgment of the Circuit Court of Appeals for the First Circuit entered July 13, 1935, in the case between the above-named parties docketed in that Court as number 3012.

OPINIONS BELOW.

An opinion entitled "Memorandum" was filed November 22, 1934, by Judge McLellan of the District Court. It has not been reported. It is found on pages 9 and 10 of the

record. The opinion of the Circuit Court of Appeals (delivered by Judge Morton) is printed at pages 13-19 of the record and is reported 78 F. (2d) 829.

Jurisdiction.

The judgment of the Circuit Court of Appeals was entered July 13, 1935 (R. 20). A petition for rehearing was filed in said Court August 6, 1935, and was denied October 9, 1935 (R. 20).

The jurisdiction of this Court is invoked under section 240 (a) of the Judicial Code as amended, U.S.C. Title 28, section 347.

The jurisdiction of the District Court over the case (which was commenced by a writ returnable to the District Court for the District of Massachusetts) was asserted by the respondent (the plaintiff) by reason of the fact that the respondent is a citizen and resident of Massachusetts and the petitioner a citizen of New York, and, as alleged, that the amount in controversy exceeded $3000 exclusive of interest and costs (U.S.C. Title 28, section 41 (1)). This jurisdiction is challenged by the petitioner.

Question Presented.

The question presented is that considered by this Court in the case of *Mobley* v. *New York Life Insurance Company*, October Term 1934, No. 751, 79 L. Ed. 936 (which was not followed by the Circuit Court of Appeals):

Whether the holder of a life insurance policy promising him monthly payments and waiver of premiums in the event that he becomes totally and permanently disabled and providing for cessation of these benefits if he ceases to be disabled may recover as damages the present value of those payments for the balance of his life expectancy and the

present value of the face of the policy when he asserts that he is so totally and permanently disabled but this is denied by the insurer, which upon his subsequent failure to pay a premium declares the policy lapsed.

The Travel of the Case and its Facts.

The case comes up upon petitioner's demurrer to the respondent's substitute declaration in an action at law. The writ was dated November 9, 1933, and its ad damnum was $15,000, subsequently (by amendment) increased to $20,000 (R. 2, 3).

The substitute declaration (R. 3-7) is based upon a life insurance policy issued by the petitioner to the respondent (R. 21). Under this policy the petitioner undertook to pay the beneficiaries (who are not parties to the litigation) $2000 upon the death of the respondent, and "upon receipt of due proof that the Insured is totally and presumably permanently disabled" (R. 23) to pay to the respondent himself $20 per month throughout the continuance of the disability and to waive payment of premiums (otherwise payable semi-annually) by the respondent throughout the same period. Careful provisions were in the policy covering this obligation (R. 23). The promise is to pay the monthly annuity "for each completed month from the commencement of and during the period of continuous total disability" and to waive premiums "falling due during the period of continuous total disability" (R. 23). Before making payments (subject to certain conditions not presently material) the petitioner might require proof of the continuance of the disability, and there was a provision expressly terminating the respondent's right to receive these benefits unless it should appear that the disability was still continuing.

The substitute declaration contains two counts. Under the first, recovery of only $1408 is sought, so it may be dis-

regarded. In the second it is alleged that on September 11, 1931, the respondent "became totally and permanently disabled within the terms and provisions of the contract," and that thereupon the petitioner honoured the claim made, paid the $20 monthly annuity to and including July 11, 1933, and waived premimus falling due prior to August 7, 1933. It is then alleged—

> ". . . that on or about September 1, 1933, the defendant refused to make the monthly payment due August 11, 1933, and refused to waive the semi-annual premium due August 7, 1933, asserting to the plaintiff as its ground for such refusal that since it appeared to the defendant that for some time past the plaintiff had not been continuously totally disabled within the meaning of the disability benefit provision of the policy, the defendant would make no further monthly disability payments, and that the premiums due on and after August 7, 1933, would be payable in conformity with the terms of the contract. Upon the expiration of the days of grace after August 7, 1933, for the payment of the semi-annual premium, the defendant on or about September 19, 1933, declared the policy as lapsed upon its records, the premiums not having been waived by the defendant nor paid by the plaintiff" (R. 6).

This is followed by an allegation that the respondent was in fact totally disabled throughout, and consequently that the refusal of the benefits was a breach by the petitioner and that the respondent "elected to treat said wrongful refusal of the defendant [petitioner] to perform its obligations under said contract as a repudiation and renunciation of the entire contract" (R. 6, 7). Upon this basis entire damages were sought, based upon the respondent's life expectancy and his anticipation that he would remain disabled, amounting to some $15,900.

To this declaration the petitioner demurred (R. 8) upon the ground that the allegations did not show a total breach and that the limit of the recovery on the allegations was the amount of accrued monthly payments and waiver of premium, amounting in all to $98, and so far below the jurisdictional requirement of more than $3000. As far as the demurrer is concerned, there has never been any dispute on the figures. The only question presented was whether the allegations showed such a breach as to allow recovery of damages which should include future indemnity which might or might not become payable depending upon future facts which could not be prophesied with any exactness.

The District Court answered this question in the negative and sustained the demurrer (R. 9, 10). In support of the declaration the respondent relied heavily on the case of *Federal Life Insurance Company* v. *Rascoe,* 12 F. (2d) 693 (C.C.A. 6). The District Court treated that case as such authority, but refused to follow it, on the ground that it was contrary to the weight of authority.

On the respondent's appeal to the Circuit Court of Appeals he took the same position and based his argument upon the authority of the *Rascoe* case. The argument took place before *Mobley* v. *New York Life Insurance Company* was argued in this Court. The opinion was handed down after the decision of this Court in the *Mobley* case and after counsel by letter to the clerk had called the attention of the Court to that decision. In the opinion (written by Judge Morton) it was held that the allegations showed a total breach and repudiation of the policy which entitled the respondent to the entire damages which he sought. The *Rascoe* case was not mentioned, and an attempt was made to distinguish the *Mobley* case.

The petitioner seasonably petitioned for a rehearing. This was denied without opinion.

Specification of Errors.

The Circuit Court of Appeals erred—

(1) In refusing to follow the decision of this Court in *Mobley* v. *New York Life Insurance Company,* 79 L. Ed. 936.

(2) In holding that the declaration showed a repudiation of its contract by the petitioner upon allegations, without more, that (*a*) the respondent was entitled to continue to receive disability benefits from the petitioner, but that (*b*) the petitioner refused to continue the benefits upon the ground (not alleged to have been taken *mala fide*) that the respondent had not met the conditions upon which only the benefits were payable, and (*c*) thereafter upon failure to receive a premium declared the policy lapsed.

(3) In ruling that, upon a total breach of a policy providing for monthly future payments conditioned upon the state of health of the policyholder at the beginning of each future month, the present value of those future payments, computed upon the assumption that the policyholders will live out the normal expectancy of an unimpaired life and continue to suffer total disability, may be recovered.

(4) In reversing the judgment of the District Court and ordering the petitioner's demurrer to the substitute declaration overruled.

Reasons for Granting the Writ.

(1) The Circuit Court of Appeals refused to follow the decision of this Court in the *Mobley* case. It was aware of the decision and sought to distinguish it.

The pertinent facts stated in this Court's opinion relied on as showing a total breach in the *Mobley* case were (79 L. Ed. 938):

> "March 1, 1933 the company wrote him stating it appeared that for some time he had not been continuously disabled within the meaning of the policies, that no further monthly payments could be made and that the premiums due on and after February 7 became payable according to the terms of the contracts . . .
>
> "April 13 it notified plaintiff that the $5000 policy had lapsed . . ."

It was held that these facts did not show a repudiation of the policy.

The pertinent and parallel allegations in the instant case are that the petitioner refused to continue benefits—

> "asserting to the plaintiff as its [petitioner's] ground for such refusal that since it appeared to the defendant that for some time past the plaintiff had not been continuously totally disabled within the meaning of the disability benefit provision of the policy, the defendant would make no further monthly disability payments, and that the premiums due on and after August 7, 1933 would be payable in conformity with the terms of the contract"—

and that upon non-payment of the August 7 premium the petitioner—

> "declared the policy as lapsed upon its records" (R. 6).

The policy provisions in the two cases were substantially identical (R. p. 23; 79 L. Ed. 937).

In spite of this parallel the Court here construed these allegations to show a repudiation of the policy, and said:

> "The facts alleged are essentially different from those in the Mobley case . . ." (R. 17).

(2) If there be any ground for distinction between this case and the *Mobley* case and the allegations do show repudiation, which we emphatically deny, this case then squarely presents the question of "whether the doctrine of anticipatory breach is applicable to the class of cases to which this one belongs," which was left open by this Court in its opinion in the *Mobley* case (79 L. Ed. 939).

The question is an important one. It has never been passed upon by this Court.

(3) The points raised are of great interest and importance. That damages like those sought here might be recovered was announced for the first time in 1926 in the majority opinion in *Federal Life Ins. Co.* v. *Rascoe,* 12 F. (2d) 693 (C.C.A. 6). Since then no effort has been spared to demonstrate the unsoundness of the majority opinion in the *Rascoe* case and to obtain an authoritative decision demonstrating that unsoundness. It was thought that those efforts had been successful when this Court announced its opinion in the *Mobley* case. The opinion of the Circuit Court of Appeals in the instant case, following the *Mobley* opinion by a scant two months, now makes the situation more confused than ever. That confusion would be resolved by a decision by this Court in the instant case.

Moreover, an important point of federal jurisdiction is involved. Actions to recover disability benefits are very common. In probably a great majority of these actions there is diversity of citizenship. In certainly an overwhelming majority the amounts of the accrued disability payments are far below $3000. In most of them the plaintiff could make allegations essentially identical with those made here by the respondent. Those allegations are printed in the Federal Reporter. Consequently it is probable that every such case arising in the future will find its way into the Federal Courts.

Such a situation merits the attention of this Court.

(4) The decision is *contra* to that of the Circuit Court of Appeals for the Tenth Circuit in—

Kimel v. *Missouri State Life Insurance Co.*, 71 F. (2d) 921.

Wherefore it is respectfully submitted that this petition should be granted.

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Attorneys for Petitioner.

In the

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No.

NEW YORK LIFE INSURANCE COMPANY,

PETITIONER,

v.

DEMETRIOS P. VIGLAS,

RESPONDENT.

BRIEF IN SUPPORT OF PETITION FOR A WRIT OF CERTIORARI TO THE CIRCUIT COURT OF APPEALS FOR THE FIRST CIRCUIT.

The facts are stated in the petition in support of which this brief is filed.

1. The Circuit Court of Appeals refused to follow the decision of this Court in Mobley v. New York Life Insurance Company, 79 L. Ed. 936.

The precise question presented upon the present record was before this Court in the case of *Mobley* v. *New York Life Insurance Company.* It will be observed that the insurer was the same in that case as in the instant case. The statement of the policy provisions contained in the opinion of the *Mobley* case indicates that the provisions relating to total and permanent disability there in suit were precisely the same as those in the policy in the case at bar. The pol-

icy provisions in the instant case cannot be described more succinctly than by following the language of the Court in that opinion. The policy provides:

> "That whenever the insured is so disabled by bodily injury or disease that he is wholly prevented from performing any work, following any occupation or engaging in any business for remuneration and the company receives proof that this disability will continue for life or that it has existed for the three months next preceding the proof, the company will pay monthly ten dollars per thousand of face value and waive premiums; that, before making any income payment or waiving any premium, the company may demand proof of continuance of total disability (but not oftener than once a year after disability has continued for two full years) and that, upon failure to furnish such proof, no further payments will be made nor premiums waived" (79 L. Ed. 937).

Mobley became disabled under circumstances which entitled him to receive the monthly payments provided in the policy. Thereafter a dispute arose between him and the insurer as to whether his disability was still persisting, and this Court stated:

> "March 1, 1933, the company wrote him stating it appeared that for some time he had not been continuously disabled within the meaning of the policies, that no further monthly payments would be made and that the premiums due on and after February 7 became payable according to the terms of the contracts" (79 L. Ed. 938).

Mobley immediately seized upon this notification as constituting a total breach of the policy which would entitle

him to recover at that time indemnity for a further period figured upon the theory that he would continue disabled and would live out his normal expectancy. The District Court for the Southern District of Mississippi, the Circuit Court of Appeals for the Fifth Circuit, and this Court all ruled that there could be no such recovery. This Court said in its opinion:

> "The evidence gives no support to the claim that it disregarded or intended to break its promises. We conclude that, as found by the lower courts—rightly declining to follow the decision of the Circuit Court of Appeals for the Sixth Circuit in Federal L. Ins. Co. v. Rascoe, supra (12 F. (2d) 696)—the company did not repudiate the policies. In view of that fact, we need not and therefore do not decide whether the doctrine of anticipatory breach is applicable to the class of cases to which this one belongs. Dingley v. Oler, 117 U. S. 490, 29 L. ed. 984, 6 S. Ct. 850, ubi supra" (79 L. Ed. 939).

In the case at bar the respondent became disabled under circumstances which led the petitioner to make monthly payments to him under his policy. The petitioner received advices that his condition had improved and refused to continue the payments. He brought suit, making the precise claim which Mobley had made. In his declaration he alleged—

> ". . . that on or about September 1, 1933, the defendant refused to make the monthly payment due August 11, 1933, and refused to waive the semi-annual premium due August 7, 1933, asserting to the plaintiff as its ground for such refusal that since it appeared to the defendant that for some time past the plaintiff had not been continuously totally disabled within the meaning of the disability benefit provision of the policy, the

> defendant would make no further monthly disability payments, and that the premiums due on and after August 7, 1933, would be payable in conformity with the terms of the contract'' (R. p. 6).

The District Court on demurrer ruled that this did not show a total breach which would support the action. The Circuit Court of Appeals held otherwise.

Obviously no distinction can be drawn between these allegations of the respondent's declaration and the evidence tending to show breach summarized by this Court in the *Mobley* case.

The Circuit Court of Appeals referred to the opinion of this Court in the *Mobley* case, but did not make any attempt to distinguish specifically between the allegations of the declaration which was before it and the facts on which this Court passed in the cited case. It contented itself with quotations from the opinion of this Court, laying down the broad general propositions of the law upon which such cases must depend and with the bare statement: ''The facts alleged are essentially different from those in the Mobley case where it was held that the evidence did not show repudiation of the policy or a complete denial of liability on it by the company'' (R. p. 17).

That statement is demonstrably not so. A comparison of the allegations of the breach in the respondent's declaration with the quotation from the opinion of this Court given above shows that there is no essential difference and indeed that both employ almost identical words. This is not extraordinary in view of the fact that both obviously were taken from the same form letter sent in such cases by New York Life Insurance Company to policyholders making claims like those of Mobley and the respondent.

The Circuit Court of Appeals made a point of the further allegation contained in the declaration that the peti-

tioner had declared the policy lapsed upon its records. The allegation of the declaration on this point was as follows:

> "Upon the expiration of the days of grace after August 7, 1933, for the payment of the semi-annual premium, the defendant, on or about September 19, 1933, declared the policy as lapsed upon its records, the premiums not having been waived by the defendant nor paid by the plaintiff" (R. p. 6).

Referring to this allegation the Circuit Court of Appeals said:

> "As we construe the declaration it alleges a complete and unqualified denial by the defendant of all liability on the policy. It states that the defendant not only refused to pay benefits due but wrongfully lapsed the policy for non-payment of premiums. An unconditional lapsing of the policy was a complete termination of it and a denial by the defendant of any further liability on it. There is no allegation that the defendant recognizes any further rights of the plaintiff in the policy, or any further liability upon it. . . . On the allegations of the declaration we are of opinion that the plaintiff was entitled to maintain the action and, if the lapsing was found to be a complete and unqualified denial by the defendant of any further liability on the policy and was unjustified that the plaintiff would be entitled to recover damages equivalent to the value to him of the contract which was broken" (R. pp. 16, 17).

But this allegation in no way distinguishes the instant case from the *Mobley* case. There also the insurer declared the policy lapsed. In both cases the company was simply referring to the express provision contained in the policies

that the policy should not remain in force beyond the date when the next premium payment should become due. It is only by a clear misconstruction of the allegations of the declaration that it is possible to say that they show "a complete and unqualified denial . . . of all liability on the policy." The notification of September 1, 1933, specifically stated that it was sent upon the ground, not that there was anything wrong with the policy, but that the respondent was not then continuously totally disabled, and it was coupled with a statement that the premiums due thereafter would be payable "in conformity with the terms of the contract"—thus specifically recognizing that the policy was then still in force.

The further notification that the policy had lapsed, sent after the time for the payment of the premium had passed, added nothing to the situation. If the premium was in fact payable, it was a simple notification that the policy had expired by its own terms. If, on the other hand, the premium should have been waived, it was entirely nugatory, added nothing to what had already gone before, and cannot be taken to indicate any intention on the part of the petitioner not to recognize its policy obligations. The situation in this respect is no different from a case where a premium has in fact been paid but through a clerical mistake the insurer does not realize the fact and advises the policyholder that the policy has lapsed. By no stretch of the imagination could such an advice be considered a breach of the provisions of the policy.

The fact that it appeared in evidence in the *Mobley* case that after the insurer had refused to continue benefits and had notified Mobley of the lapse of its policy it reversed its decision and tendered benefits to Mobley, which were refused, forms the basis for no distinction between the two cases. Mobley brought his action on the basis that there had then accrued to him a complete cause of action to re-

cover the entire amount sought, and that nothing done thereafter by the defendant could change the situation. It was on this basis that the case was decided. The behaviour of the insurer after the action was commenced was pertinent on the question of whether the original refusal to continue the benefits was made in good faith or not. In the present case this issue is not presented, since there are no allegations in the declaration that the petitioner did not act in good faith and the asserted ground of its action was one which was clearly open to it entirely irrespective of whether it may have been wrong in its understanding of the factual situation.

There are no allegations in the declaration that the petitioner took its position in anything other than entire good faith or that it disregarded or intended to break its promises. The attempted distinction of the two cases by the Circuit Court of Appeals has not even a superficial plausibility. There can be no escape from the conclusion that the Circuit Court of Appeals deliberately refused to follow the opinion of this Court.

2. The question of "whether the doctrine of anticipatory breach is applicable to the class of cases to which this one belongs" merits the consideration and opinion of this Court.

The substitute declaration contains an allegation that after petitioner had notified respondent that the policy had lapsed he "elected to treat said wrongful refusal of the defendant to perform its obligations under said contract as a repudiation and renunciation of the entire contract" (R. 6, 7). This obviously was included with a view to establishing a cause of action based upon an anticipatory breach. The Circuit Court of Appeals held that the doctrine of an-

ticipatory breach had nothing to do with the case (R. 17). We agree that that doctrine cannot apply, but we also submit that, unless it can apply, the respondent could not recover enough to meet the jurisdictional requirement, whatever the allegations showing breach.

Unless the breach amounted to an unequivocal refusal under any circumstances ever to pay the respondent anything further under the policy no question of the recovery of entire damages can arise on a theory either of present breach or of anticipatory breach. We believe we have demonstrated that the allegations do not show an unequivocal refusal any more than the facts in the *Mobley* case did. If, however, there is some ground for distinction which our industry has been unable to disclose, then the question of anticipatory breach becomes important and the statement of the Circuit Court of Appeals that it had nothing to do with the case becomes erroneous when taken with its order overruling the demurrer.

The doctrine of anticipatory breach is that, where one party to a contract containing mutual executory obligations before the time for his performance repudiates, the other may immediately recover damages for the non-performance of the future obligation.

See *Roehm* v. *Horst,* 178 U.S. 1.
Daniels v. *Newton,* 114 Mass. 530.
Parker v. *Russell,* 133 Mass. 74.

It was upon the theory that this doctrine applied to a case where an insurer refuses to continue disability payments that damages such as those sought by the respondent were first awarded.

Federal Life Insurance Co. v. *Rascoe,* 12 F. (2d) 693 (C.C.A. 6).

And later federal cases discussing the point put it upon that footing

Kimel v. *Missouri State Life Insurance Co.*, 71 F. (2d) 921 (C.C.A. 10).

Menssen v. *Travelers Ins. Co.*, 5 Fed. Supp. 11 (E.D. N.Y.).

Kithcart v. *Metropolitan Life Insurance Co.*, 1 Fed. Supp. 719 (N.D. Mo.).

Wyll v. *Pacific Mutual Life Insurance Co.*, 3 Fed. Supp. 483 (N.D. Tex.).

Hines v. *Fidelity Mutual Life*, 6 Fed. Supp. 692 (E.D. N.Y. 1934).

That is the only footing upon which it can be considered.

The obligation in these cases is not one single continuing one already accrued to make periodic payments for an indeterminate time. The Circuit Court of Appeals construed it in that way, and on the authority of *Pierce* v. *Tenn. &c. R.R. Co.*, 173 U.S. 1, and *Parker* v. *Russell*, 133 Mass. 74 (which undoubtedly hold that in such case entire damages are recoverable), overruled the demurrer. In this it was wrong. The obligation of the insurer is purely conditional with reference to each possible payment, and the conditions are ones of future fact which involve no correlative obligation of the insured. Assume the respondent is so disabled on July 11, 1933, as to require a $20 payment. On that day the petitioner is under a present obligation to pay him $20. If on August 11, 1933, also he is so disabled, another $20 obligation will then accrue, but not until that day. On July 12, 1933, or August 10 the petitioner owes him nothing, and is not then under a present obligation to pay him $20 on August 11th. Not until the conditions are all met does the obligation arise. Meanwhile the insured is under no contractual obligation from which he ought to be relieved by election to sue at once.

That this is the proper construction of the contract is shown by the discussion in the *Mobley* opinion, where this Court said:

> "The insurer's promise to pay monthly benefits was conditional on two events: the insured's disability as defined, and the specified proof. Its obligation was not an unqualified one to pay or to pay on the mere occurrence of disability but only after proof of that fact. Similarly its agreement to continue payments once begun was conditioned upon the persistence of insured's disability and, at the election of the insurer, proof of that fact by physical examination, but after two years not oftener than once a year. These conditions serve to define the insurer's promises but impose no obligation on the insured. By payment of the premium he acquired the options and privileges specified. He did not promise or in any manner bind himself to do or refrain from doing anything. The provision that the company may require proof of continuance of disability conditions the right of the insured to have future installments but imposes no obligation upon him. He was at liberty, without breach of contract, to refrain from making the claim or to refuse disclosure of his condition or to permit examination" (79 L. Ed. 939).

Assuming repudiation, therefore, there is no present breach of an obligation to pay future benefits, for there is no such present obligation. *Parker* v. *Russell, supra,* and similar cases cannot apply (133 Mass. at p. 76), and if damages are to be recovered, it must be upon the doctrine of anticipatory breach. But that doctrine requires mutual obligations; otherwise, as in the case of negotiable paper, it does not apply.

Roehm v. *Horst,* 178 U.S. 1, 17.

Here, as this Court pointed out in the *Mobley* case, there are no mutual obligations.

This difficulty was recognized by the majority in the *Rascoe* case and was evaded by construing the conditions into obligations resting upon the insured (12 F. (2d) 693, 696). The dissent (see p. 697) clearly shows that this was a misconstruction, and this Court has settled that matter by the statement just quoted.

If we are wrong, therefore, in our reading of the allegations showing breach, and they do establish a repudiation, this point of anticipatory breach is squarely raised upon the present record. Its importance was recognized by this Court when the question was expressly reserved at the end of the *Mobley* opinion. We hope the Court will now consider it.

3. The matter is one of great practical importance.

It is important to the petitioner and to all insurance companies to have the outstanding opinion of the Circuit Court of Appeals corrected.

If the opinion is to stand unreversed, all insurance companies with outstanding policies carrying disability benefits will be placed in a most unfortunate position.

This Court is of course aware of the great volume of litigation carried on by insurers relating to disability benefits. That type of insurance invites litigation perhaps more than any other type. There are very many policyholders who are suffering from some degree of physical disability. There is no room for question that many are able to pursue gainful employment. Others are as undoubtedly truly totally disabled. Between the extremes there is a great host of people as to whom it is impossible to say categorically that they are or are not able to work and earn money —given the opportunity. Each of them insists (honestly or

not) that he cannot do so. The most vexing situation arises in the cases of those policyholders who have been receiving benefits but whose disability is disappearing. People who are totally disabled (even when they hold insurance policies) do get better and become able again to carry on gainful occupation. When that happens the insurer has a right to stop the benefits. But if a jury finds otherwise upon the issue of degree of disability, the First Circuit would permit damages upon the theory that the insured will live many years and be totally disabled all the time.

Justice requires that the insurer should have the opportunity to litigate its contention quite as much as it requires that the truly disabled policyholder should receive his benefits. In each case the insurer's contention is precisely the same—the insured can now work and so the condition on which the benefit depends is not met. Consequently in each case the insurer says just that to the insured, who then brings suit if he disagrees. Prior to the *Rascoe* case (1926) that was a perfectly simple situation. If the insurer won, well and good; if it lost, the judgment merely required payment of the accrued indemnity and then payments were continued in the normal course until some further change occurred in the factual situation. Ordinarily only a few hundred dollars would be at stake.

But in 1926 Rascoe's lawyers succeeded in holding an insurer liable for $25,000, in just such a situation. If the law announced in that opinion was sound, the entire complexion of the situation had changed. The insurer was then faced with the necessity of meeting the claim, not only that the insured was still disabled at a possible cost of a few hundred dollars, but also that it had repudiated its policy, at a possible cost of many thousand. The result was that the litigation of disability claims became a most hazardous matter, and a perfectly honourable insurer might well hesi-

tate putting a perfectly honest and reasonable claim in litigation at such a stake.

It is against the policy of the law to subject litigants to such a hazard in settling bona-fide disputes. *Kimel* v. *Missouri State Life Insurance Co.*, 71 F. (2d) 921, 923 (C.C.A. 10).

In consequence, throughout the past nine years insurers have lost no opportunity to demonstrate that the *Rascoe* case is not good law. Until the present case they have met with consistent success at least in the Federal Courts. But now, unless this Court straightens the matter out, they are faced with a worse opinion than that in the *Rascoe* case—which at least was coupled with a well-reasoned dissent. In the report of that case the facts relating to the supposed "repudiation" are obscurely stated and the furthest that it goes is as authority for the proposition that, if there is repudiation, there can be recovery of entire damages. What constitutes repudiation is not discussed at length. But the opinion in the case at bar announces that a refusal to pay upon the asserted ground that "it appeared . . . that for some time past the plaintiff had not been continuously totally disabled" (R. p. 6), followed by a declaration that the policy has lapsed for non-payment of premium, is sufficient to constitute repudiation. That is an invitation to every disgruntled policyholder to claim entire damages in every case.

There is no occasion to doubt that the invitation will be accepted. Each case which formerly involved an insignificant amount will now involve enough to bring it within the jurisdiction of the Federal Courts. In a very great number of the cases there will also be the requisite diversity of citizenship. The consequence is that these cases will be brought in the Federal Courts. In view of the chilly reception accorded to the *Rascoe* case outside of the Sixth Circuit, there is no reason to suppose that the instant case will

be better received in the other circuits. Confusion will follow, with consequent injustice to the litigants which this Court will undoubtedly right sooner or later.

We do not believe this Court will approve the opinion of the Circuit Court of Appeals in this case. We are certain that it is to the great interest of the law that it settle the matter now once and for all.

Respectfully submitted,

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